STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING _____ B. WING _____	C 06/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for Investigation of Complaint IN00090903. Complaint IN00090903 - Substantiated. Federal/state deficiencies related to the allegations are cited at F241, F272, F279, F282, F309, F312, F314, F328, and F353. Unrelated deficiencies are cited. Survey dates: 6/6 and 6/7/11 Facility number: 000059 Provider number: 155697 AIM number: 100266560 Survey team: Jennie Bartelt, RN Census bed type: SNF: 7 SNF/NF: 64 Total: 71 Census payor type: Medicare: 13 Medicaid: 53 Other: 5 Total: 71 Sample: 20 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/13/11 Cathy Emswiller RN	F 000		
F 157	483.10(b)(11) NOTIFY OF CHANGES	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157 SS=D	Continued From page 1 (INJURY/DECLINE/ROOM, ETC)	F 157		

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure the physician was notified as

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ordered for possible change in treatment when two doses of a medication were ineffective for treatment of chest pain. The deficient practice affected 1 of 7 residents reviewed related to physician notification in a sample of 20. (Resident P)

Findings include:

During interview on 6/7/11 at 5:00 p.m., Resident P indicated she had chest pain on the Memorial Day holiday around suppertime. She indicated she took three nitroglycerin tablets that evening.

The clinical record for Resident P was reviewed on 6/7/11 at 5:30 p.m.

Physician's orders for May 2011 included, but were not limited to, an order received 1/18/08, for "Nitroglycerin 0.4 mg sub [sublingual], Take 1 tablet sublingually every 5 minutes times 2 doses as needed for chest pain - if no relief notify MD."

Nurse's Notes for 5/30/11 indicated the Nitroglycerin was administered sublingually at 7:00 p.m., and was ineffective; at 7:05 p.m., and was ineffective; and at 7:10 p.m., and was ineffective. Documentation failed to indicate the physician was notified after two doses of Nitroglycerin were administered. A third dose of nitroglycerin was administered without physician's order.

During interview on 6/7/11 at 6:00 p.m., the Director of Nursing indicated the nurse who provided the care had been terminated related to customer relations and other care issues.

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F 157	Continued From page 3 3.1-5(a)(3)	F 157		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide privacy during care for 6 of 6 residents reviewed related to receiving privacy	F 164		

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F 164	Continued From page 4 during care in a sample of 20. (Residents G, H, I, F, C, and J) Findings include: During the Entrance Conference on 6/6/11 at 10:00 a.m., the Administrator indicated the facility's podiatrist and optometrist were providing services to residents that day. 1. During the Initial Tour on 6/6/11 at 10:20 a.m., Resident G was observed through the open door to the hallway between the nurse's station and the area where residents had gathered for a music program. The resident was seated in a chair, and the curtain was not pulled around the resident. A man in a blue uniform was observed talking with the resident and using a tool to provide care to the resident's left foot. The man completed the task and then assisted the resident to don the right sock and shoe. On 6/6/11 at 11:10 a.m., the assistant of the man in the blue uniform was observed in the hall outside the room and was overheard telling CNA #4, "I need him [Resident J] for the foot doctor." 2. On 6/6/11 at 10:55 a.m., a man dressed in street clothes was observed entering a resident's room, and was overheard saying, "I'm Dr. [name], the eye doctor." On 6/6/11 at 3:30 p.m., Resident H was observed seated in a chair in Room 9 facing an eye test chart mounted on the wall across the room. The resident was reading aloud, naming letters from the eye chart to the man who had identified himself as the eye doctor. 3. On 6/6/11 at 3:45 p.m., a resident was seated in a wheel chair in Room 9. The room was	F 164		

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darkened, and the eye doctor was seated next to the resident was holding a device in front of the resident and shining a light into her eye. The eye doctor's assistant was observed outside the room with clinical records on a table. During interview at this time, the assistant indicated the resident being examined was Resident I.

4. During the Initial Tour on 6/6/11 at 10:05 a.m., CNA #6 was observed through the open door to the hallway in Resident F's room next to Resident F's bed with a Hoyer lift. Resident F was in bed, the bed curtain was not pulled around the bed, and the Hoyer lift sling was under the resident. CNA #6 turned the lift on, and the resident was observed being lifted from the bed. At this time, CNA #20 was observed coming down the hall, entering the room and closing the door.

5. During observation of incontinent care on 6/6/11 at 12:30 p.m., Resident C was taken by wheel chair into his room by CNAs #6 and #2. The resident's window blinds were open with a view directly onto the resident's smoking porch where a resident was seated. The curtains were not pulled around the resident's bed. The resident was transferred from wheel chair to bed, and incontinence care was provided. During care, CNA #6 was interviewed related to a reddened area on the resident's left hip. At this time CNA #6 indicated he needed more light to see the area, looked up, and indicated they "forgot to shut the curtains." The window blinds were closed, but the curtain was not pulled between the resident's bed and the doorway.

6. On 6/7/11 at 2:50 p.m., RN #5 was observed providing a skin assessment for Resident J. The

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F 164	Continued From page 6 resident was in bed. The resident's window curtains were half open with view to a grassy area outside the window. The curtains were not pulled around the resident's bed to block view of the window or door. The resident was wearing socks and a shirt in bed, and the remainder of the resident's body was bare. 3.1-3(p)(2) 3.1-3(p)(4)	F 164		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents were provided dignified care related to wheel chair transport, toileting, personal care before a doctor's visit, clothing choice, dining, and a pleasant atmosphere during leisure activities for 8 of 8 residents reviewed who were affected by undignified care in a sample of 20. (Residents P, F, O, Q, D, K, J, and R) Findings include: 1. During the Initial Tour on 6/6/11 at 10:10 a.m. in the beauty shop, Resident P was interviewed and indicated she was in the shop visiting with Beautician #1. Resident F was observed in her wheel chair being pushed by CNA #6 from the	F 241		

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hallway into the beauty shop. As Resident F was wheeled into the shop, Resident P indicated, "Here comes Miss [name of Resident F]." Resident F was observed to be wearing a short dress that came just to the top of the thighs, when seated in the wheel chair. The resident's legs were not together, the resident was not wearing undergarments, and she had no covering over the lap and knees. The resident's private area was in full view.

2. On 6/6/11 at 10:45 a.m., CNA #16 was observed exiting from the room of Residents O and Q. Upon entry into the room, Resident Q was observed in bed and was interviewed. During the interview, from the head of Resident Q's bed, the door to the residents' shared restroom was observed to be part way open, and visible through the door was a lift in front of the toilet, and a resident's seated legs with brief down were in view. CNAs #16 and #2 entered the room and indicated they would assist Resident O off the toilet.

3. During observation on 6/6/11 at 10:55 a.m., the call light for Resident D's room was on. During interview at this time, Resident D indicated she needed to be changed. The resident's visitor indicated staff was busy, and Resident D indicated she had already asked twice to be changed. At this time, a man entered the room, and indicated he was "...Dr. [name], the eye doctor," and he closed the door. At 11:00 a.m., CNA #2 knocked on Resident D's door, cracked the door to look in, and stepped back. CNA #2 indicated she was planning to change the resident now, but the resident was having her exam. At 11:15 a.m., the call light for Resident

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D's room was observed to be on. The eye doctor was no longer in the room, and during interview at this time, Resident D indicated she had not been changed yet. At 11:20 a.m., Restorative Aide #8 answered the call light. During interview on 6/6/11 at 12:05 p.m., Resident D indicated her brief had been changed now, but she was soaked and her brief unchanged from 7:00 a.m. until after the eye doctor's visit.

4. During observation of the lunch meal in the restorative dining room on 6/6/11 at 12:20 p.m., Resident K was observed seated at a table by himself, facing out the window. The closest staff was two tables away, seated feeding other residents. The resident had a plate with lettuce topped with chicken salad, a bowl of beets, a bowl of red Jello, a bowl with Mandarin orange slices, and two glasses of lemonade. The resident's silverware was rolled in a white napkin to the side of the plate. The food appeared to be partially eaten. The resident was observed to pick up beets with his fingers and feed himself. The outside of the resident's cups had bits of orange section stuck to them, and his hands had chicken salad stuck to them. On the clothing protector on the resident's lap was chicken salad and orange sections, and the resident picked food up off the clothing protector with his fingers and attempted to feed himself that.

The clinical record for Resident K was reviewed on 6/6/11 at 3:50 p.m.

A physician's order, dated 2/11/11 indicated Occupational Therapy was to evaluate and treat, and the Care Plan Update for 2/11/11, indicated problems including, but not limited to, decreased

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self-feeding and increased spillage throughout meals.

The Occupational Discharge Summary, dated 5/3/11, indicated, "Resident is at max [maximum] level of function at this time. Resident continues to like to eat at table in 40 hall dining room facing toward the window....Resident is feeding self with set-up only....Staff needs to continue with initiation and attention to task cuing."

Review of the CNA Assignment Sheet, provided by the Assistant Director of Nursing on 6/6/11 at 10:05 a.m., indicated in Special Needs for Resident K: "...Res [resident] to be 1 on 1 for all meals. Staff to assist to RDR [restorative dining room] stay with resident while eating...."

5. During interview on Initial Tour of the facility on 6/6/11 at 10:15 a.m., a family member of Resident J indicated concern related to Resident J's clothing and the availability of his clean clothes. The family member indicated she had just arrived at the facility and the resident was dressed in his pajamas and a long sleeve shirt. The family member indicated she wanted the resident dressed in jeans and a short sleeved polo shirt and had provided plenty of jeans and polo shirts.

Upon the family member's request, the resident's closet was observed at this time, and there were no jeans and one polo shirt hanging in the closet. The family member indicated the facility took Resident J's laundry to the local laundromat, since he was allergic to bleach in the facility's automatic laundry system. She indicated the facility did not consistently do wash at the

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laundromat to keep the resident supplied with clean jeans. She indicated she had been told the facility ran out of money to pay for the laundromat.

Upon request, the resident was observed at this time during participation in a music activity. Resident J was observed wearing long flannel draw string pants and a long sleeved jersey.

During interview on 6/6/11 at 1:45 p.m., CNA #4 indicated Resident J and his family like for him to wear jeans but "there were none in the closet today."

During interview on 6/7/11 at 2:45 p.m., RN #5 indicated sometimes Resident J ran low on laundry, including jeans, which the family liked him to wear.

6. On 6/7/11 at 11:05 a.m., Resident R rolled down the hall in his wheel chair and indicated he had been "looking for you all morning - aren't you the state [Indiana State Department of Health]?" During interview at this time, Resident R indicated he was concerned about a disruption he experienced the preceding evening. The resident indicated he liked to sit at the nurse's station, where the lighting was good, to read at night. He indicated he was reading the preceding evening when his reading was disrupted by the Assistant Director of Nursing (ADON) yelling. When asked if staff was yelling at residents, Resident R indicated the yelling was only directed at staff. The resident indicated he was concerned that more staff would quit, and they didn't have enough staff already.

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F 241	Continued From page 11 During interview on 6/7/11 with the ADON, she indicated she had been in the building the preceding evening to provide staff inservice. She indicated a problem had arisen with staff who voiced a complaint. She indicated the problem could have been managed more effectively. This federal tag relates to Complaint IN00090903. 3.1-3(t)	F 241		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272		

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F 272	Continued From page 12 Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents were assessed and/or accurately assessed related to wounds, pain, and change in bowel function for 3 of 7 residents reviewed related to assessments in a sample of 20. (Residents B, J, and D) Findings include: 1. On 6/6/11 at 12:50 p.m., CNAs #2 and #16 were observed providing incontinence care for Resident B. CNA #16 indicated the resident's leg was "really hurting." She indicated she had surgery to the left but is hurting on the right, too. CNA #16 indicated her "bottom is broken down." She also indicated the "nurse took the stitches out today [incision from repair of fractured left hip] - she did have a dressing." CNA #16 indicated this was the third time since 6:45 a.m. that the resident had been cleaned up after a bowel movement. The resident's upper left leg was observed to have two lines of tiny scabs where	F 272		

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staples had been removed. A band-aid was placed cross-wise at the upper end of the incision line. The resident's buttocks, including on a dressing to the right and left buttock, were soiled with soft dark/black stool. CNA #2 indicated, "Her patch [dressing] is coming off." As the resident was moved from side to side and cleaned, she moaned and cried out "Oh." More soft black stool was observed coming from the rectum. When asked if she was hurting, the resident indicated, "Um, hum." During care, the cloth used to cleanse the buttocks of stool was observed to have small amounts of blood. CNA #2 indicated they needed to tell the nurse about the dressing coming off so it could be replaced, and about the resident's pain. CNA #2 also indicated the resident's stool was usually dark, which she thought was due to the resident's taking iron supplements.

On 6/6/11 at 2:20 p.m., LPN #7 and CNA #22 were observed at Resident B's bedside, as LPN #7 prepared to change the soiled dressing. LPN #7 asked the resident, "You still don't feel good? You want a pain pill when we get done?" The nurse cleaned black stool from the resident's buttocks and then removed the soiled dressings, one to each buttock, and then completed the cleaning of stool. The buttocks were noted to have reddened areas about the same size on the right and left buttock. The nurse indicated the left buttock was an open area. She indicated the right area, including the red dots, looked like excoriation to her. She indicated she could see some pin point open areas to the right buttock also. The resident said "Ouch" when the buttocks were cleansed with normal saline before the new dressing was applied.

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F 272	Continued From page 14 On 6/6/11 at 5:15 p.m., Resident B was observed in bed. During interview at this time, she indicated her bowels were hurting. She indicated the bowels hurt when they tried to move. The resident indicated the left hip was hurting also. LPN #11 was notified of the resident's complaints of pain. The clinical record for Resident B was reviewed on 6/6/11 at 3:10 p.m. The record indicated the resident was readmitted to the facility on 5/16/11 following surgical repair to a left hip fracture following a fall from the wheelchair. The American Senior Communities Nursing Admission Assessment, dated 5/16/11, indicated the resident had pain in the left hip and headache. Related to the skin, the Admission Assessment indicated the resident had bruises to the forehead, nose, eyes, right neck, abdomen, a scab on the nose, and staples to the left hip and upper thigh. No pressure areas to the heels or buttocks were indicated. The assessment indicated the resident's usual bowel pattern was "QD [daily]." Nurse's Notes for 6/1/11 at 3:00 p.m. indicated, "...NO [new order] received NO Tx [treatment] to buttocks cleanse area [symbol for with] NS [normal saline] pat dry apply Silvadene and cover with Allevyn q[every] days r/t [related to] open area...." A Pressure Wound Skin Evaluation Report, dated 6/1/11, indicated a Stage 2 pressure wound 5.5	F 272		

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cm long by 2 cm wide by 0.1 cm deep. The site of the ulcer was not indicated. Documentation on Pressure Wound Skin Evaluation Reports failed to indicate other pressure wounds. During interview on 6/6/11 at 3:45 p.m., the Director of Nursing [DON] indicated she keeps a binder of information on any pressure wound in the facility. The DON indicated she had only one pressure ulcer wound sheet for Resident B.

Nurse's Notes for 6/6/11 at 3:00 a.m. indicated, "C/O [complained of] pain PRN [as needed] pain med given for relief...Watery diarrhea Immodium given for relief bandages to buttocks changed r/t soilage...abd [abdomen] soft B/S [bowel sounds] X 4 quads [quadrants]....]

Nurse's Notes for 6/6/11 at 7:30 a.m. indicated, "Staples removed from L [left] hip 24 staples completely intact came out resident tolerated well...."

No further documentation related to assessment of the resident's hip pain, wounds to the buttocks, or bowel pain was indicated in Nurse's Notes from 6/6/11 at 7:30 a.m. until 6/7/11 at 7:15 a.m.

A physician's order was received 6/6/11 at 5:30 p.m. to discontinue Lortab 5/500 mg as needed and "Start Lortab 5/500 mg, take i [one] po [by mouth] q [every] 6 [symbol for hours] routine."

The ADL [activities of daily living] Record for June 2011 indicated the resident had three large incontinent bowel movements on day shift on 6/6/11, 4 large incontinent bowel movements on evening shift on 6/6/11, and four medium loose bowel movements on day shift on 6/7/11.

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The next Nurse's Note was 6/7/11 at 7:15 a.m., and indicated, "...Abd soft BS +...c/o hip pain. rec'd prn [as needed] Lortab = eff [effective] [The order was changed the preceding day.] Staples intact [The staples were removed the preceding day]...."

On 6/7/11 at 2:40 p.m. LPN #9 was observed at the nurse's station completing paperwork related to transfer of Resident B to the hospital. CNA #22 was at the station also, and during interview indicated she had changed the resident, and her stool was similar to yesterday. CNA #22 indicated she needed to clean the resident again, including cleaning blood from the resident's incision site. LPN #9 indicated "It was clean this morning - it was not like that."

A physician's order received by LPN #9 on 6/7/11 indicated, "NO rec'd sent Pt [patient] to [name of local hospital] ER [Emergency Room] for eval [evaluation] r/t dehist [sic] of L [left] hip incision."

During observation of Resident B on 6/7/11 at 3:05 p.m., Resident B was observed to have abdominal pads taped to the upper part of the left hip incision line. LPN #11 was assessing the resident and indicated, "It was enough blood to send her to the hospital." CNA #22 indicated she had already cleaned the resident, and she indicated the resident's stools were more loose than usual.

During interview completed on 6/7/11 at 2:25 p.m., the Director of Nursing indicated she had a call out to LPN #7 to find out about further documentation of assessment of the resident's

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buttocks wounds, pain, and change in bowel function.

2. The clinical record for Resident J was reviewed on 6/6/11 at 2:45 p.m. The record indicated the resident was readmitted to the facility on 3/10/11 after hospitalization on 3/6/11 for treatment to a boil on the back. Treatment at the hospital had included surgical debridement of the wound, and follow-up care included use of a wound vac for management of the wound.

A physician's order from the surgeon treating the wound, dated 5/20/11, indicated, "D/C [discontinue] wound vac cont. [continue] wet to dry dressings until would closed [symbol for with] Dakins 1/8 % strength. Dakins 1/8% strength sol [solution] apply to gauze 1 X D [daily] or prn [as needed]."

Documentation in Nurse's Notes failed to indicate a complete assessment of the wound including measurements. Occasional Nurse's Notes from 5/20 through 6/6/11 indicated the wound had no odor and slight amount of sersanguinous drainage. On 5/29/11 at 11:00 a.m., a Nurse's Note indicated, "...Granulation present at margins of wound. [symbol for no] drainage or odor...." No other documentation in Nurse's Notes described the wound.

On 6/6/11 at 3:45 p.m., the Director of Nursing (DON) was interviewed related to the ongoing assessment of the resident's wound since removal of the wound vac. The DON indicated she kept a binder containing documentation of residents' pressure wounds, but she did not keep a record of non-pressure wounds. She indicated

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nurses on the floor would be documenting non-pressure wounds, and she would check with the Medical Records Director to determine if the record of Resident J's wound to the back had gotten into the overflow record. On 6/6/11 at 4:05 p.m., the Medical Records Director indicated she was unable to find any records related to assessment of the wound on Resident J's back.

3. During interview at the bedside of Resident D on 6/7/11 at 11:25 a.m., the resident was observed to have a bandage on the right forearm. The resident indicated a bruise on the arm "busted open" when she was turned in bed.

During interview on 6/7/11 at 12:20 p.m., the Director of Nursing (DON) indicated the wound on Resident D's arm started as a skin tear. She indicated the resident would pick at the wound, and get it bleeding, and the dressing would sometimes have to be changed several times a shift. The DON indicated the resident was sent to the wound clinic for follow-up. The DON checked her skin treatment binder and indicated she did not have a wound document for tracking the resident's non-pressure wound.

The clinical record for Resident D was reviewed on 6/7/11 at 12:45 p.m.

Nurse's Notes for 5/17/11 at 1:30 p.m. indicated a physician's order was received to "Cleanse R [right] forearm [symbol for with] NS [normal saline]. Pat dry. Apply Bacitracin and apply pressure dressing [symbol for with] Kerlix BID R/T [related to] scab area...." Documentation failed to indicate a complete assessment of the wound.

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F 272	Continued From page 19 On 5/26/11 at 9:00 p.m., a physician's order was received to "Cleanse wound on R lateral forearm [symbol for with] soap & water, apply aquacel ag & cover [symbol for with] tegaderm. [Symbol for change] every 2 days." Nurse's Notes from 5/17/11 through 6/7/11 failed to indicate a complete assessment of the wound, including measurements. Documentation included, but was not limited to: 5/18/11 at 9:30 a.m., "...Site edematous with bloody drainage;" 5/21/11 at 3:35 a.m., "...area bigger in size than couple days ago...;" 5/21/11 at 1:50 p.m., "...Site red with drainage...;" 5/24/11 at 7:00 p.m., "...site edematous with drainage...;" 5/26/11 at 8:30 a.m., "...Site edematous with bloody drainage...;" 5/29/11 at 3:30 a.m., "had it bleeding earlier in shift...; 6/2/11 at 8:00 p.m., "...pressure dressing applied r/t [related to] bleeding...;" 6/3/11 at 12:30 p.m., "...Drsg [dressing] saturated with blood...R forearm hemorrhaging...." Notes indicated the resident was sent to the emergency room for evaluation and treatment due to the hemorrhaging and returned the same day. No change in wound care orders was indicated. 6/5/11 at 9:15 a.m., "...Site red/edematous with bloody drainage...." The facility's policy entitled, "Skin Management Program, dated 3/10, was provided by the Administrator on 6/7/11 at 3:40 p.m. The Procedure section indicated, "...All alterations in skin integrity will be documented in one of two skin evaluation reports depending on what type of wound - either pressure wound (white) or other wound (lavender)...." This federal tag relates to Complaint IN00090903.	F 272		

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F 272	Continued From page 20 3.1-31(a)	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure care was planned and the plan updated for the resident's non-pressure wounds for 1 of 2 residents reviewed related to non-pressure wounds in a sample of 20. (Resident J) Findings include:	F 279		

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The clinical record for Resident J was reviewed on 6/6/11 at 2:45 p.m. The record indicated the resident was readmitted to the facility on 3/10/11 after hospitalization on 3/6/11 for treatment to a boil on the back. Treatment at the hospital had included surgical debridement of the wound, and follow-up care included use of a wound vac for management of the wound.

A physician's order from the surgeon treating the wound, dated 5/20/11, indicated, "D/C [discontinue] wound vac cont. [continue] wet to dry dressings until wound closed [symbol for with] Dakins 1/8 % strength. Dakins 1/8% strength sol [solution] apply to gauze 1 X D [daily] or prn [as needed]."

The resident's Plan of Care related to the wound, dated 2/2/11, indicated a problem of "Surgical debridement to back [symbol for with] wound vac." The problem was updated 3/23/11 with a problem of "Altered skin integrity r/t [related to] surgical I&D [incision and drainage] on back. The goal for 3/23/11 indicated, "Area will [followed by blank space]." Printed interventions on the care plan were related to the problem of pain related to impaired mobility related to Parkinson's disease, another problem listed on the same care plan form. A handwritten intervention indicated, "Encourage rest & assist [symbol for with] repositioning [symbol for with] c/o [complaints of] pain." Documentation failed to indicate goals and interventions for management of the non-pressure wound had been developed.

During interview on 6/6/11 at 1:45 p.m., RN #5 indicated the dressing on Resident J's back is usually changed on second shift, unless the

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F 279	Continued From page 22 dressing comes off or is soiled. RN #5 indicated the wound is looking "wonderful." She indicated the wound has progressed better than she expected it would. On 6/7/11 at 2:50 p.m., RN #5 was observed completing a skin assessment for Resident J. A sign on the resident's door indicated, "Stop. See Nurse before Entering." During interview at this time, RN #5 indicated she would gown and glove, since she would come in contact with the resident's skin, and the resident had a dressed wound which had been positive for MRSA (Methicillin Resistant Staphylococcus Aureus), but was no longer draining. Resident B was lying in bed, and the nurse assisted the resident to roll from side to side. A dressing with the date of 6/7/11 written on it was observed on the resident's left upper left back. The facility's policy entitled, "Skin Management Program," dated 3/10, was provided by the Administrator on 6/7/11 at 3:40 p.m. The Procedure section indicated, "....The care plan will be initiated to include specific alterations in skin integrity...." This federal tag is related to Complaint IN00090903.	F 279		
F 282 SS=D	3.1-35(a) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure the physician was notified as ordered when two doses of a medication were ineffective for treatment of chest pain, and a third dose was administered without a physician's order. (Resident P) The facility also failed to ensure oxygen was administered as ordered and care planned. (Resident J) The deficient practice affected 2 of 7 residents reviewed related to following physician's orders and the care plan in a sample of 20.

Findings include:

1. During interview on 6/7/11 at 5:00 p.m., Resident P indicated she had chest pain on the Memorial Day holiday around suppertime. She indicated she took three nitroglycerin tablets that evening.

The clinical record for Resident P was reviewed on 6/7/11 at 5:30 p.m.

Physician's orders for May 2011 included, but were not limited to, an order received 1/18/08, for "Nitroglycerin 0.4 mg sub [sublingual], Take 1 tablet sublingually every 5 minutes times 2 doses as needed for chest pain - if no relief notify MD."

Nurse's Notes for 5/30/11 indicated the Nitroglycerin was administered sublingually at 7:00 p.m., and was ineffective; at 7:05 p.m., and was ineffective; and at 7:10 p.m., and was ineffective. Documentation failed to indicate the

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physician was notified after two doses of Nitroglycerin were administered. A third dose of nitroglycerin was administered without physician's order.

During interview on 6/7/11 at 6:00 p.m., the Director of Nursing indicated the nurse who provided the care had been terminated related to customer relations and other care issues.

2. During observation on 6/6/11 at 10:20 a.m., Resident J was observed in a sitting room with other residents listening to piano music. On the back of the resident's chair was an oxygen canister with tubing connected and on the resident by nasal canula. The resident's daughter was present, and she lifted the canister to show oxygen was in the canister. The canister was set at "2" LPM (liters per minute).

During observation on 6/6/11 at 4:00 p.m., LPN #3 was requested to assist with observation of Resident J's oxygen administration. The resident was observed lying in bed on his right side. The resident's portable oxygen canister was observed hanging on the back of the chair without tubing attached. The resident's oxygen concentrator was observed next to the bed with no tubing attached, and the machine was not turned on. During interview at this time, LPN #3 indicated she did not know where Resident J's oxygen tubing was, and she would get him a new one to get his oxygen hooked up and started.

During observation on 6/6/11 at 5:15 p.m., Resident J was in his geri-chair in the dining room with oxygen by nasal canula set at "2."

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The clinical record for Resident J was reviewed on 6/6/11 at 2:45 p.m. and indicated physician's orders for June 2011 including, but not limited to, an order originally received 3/10/11 for "O2 [oxygen] 3L [liters] via nasal canula continuously."

The resident's Plan of Care, with original date of 3/16/10, indicated a problem, "Potential for shortness of breath, chest pains, edema, high BP [blood pressure] due to history of CHF [congestive heart failure]. A second problem listed on the same plan of care was dated 2/2/11, and indicated, "O2 [oxygen] use res [resident] does remove O2 @ X's [at time] by self." Interventions included, but were not limited to, "...medications as ordered."

During observation in the hallway outside Resident J's room on 6/7/11 at 10:55 a.m., RN #5 was asked to check the oxygen level and setting on Resident J's portable tank. During interview at that time, RN #5 indicated the tank was set at "2." RN #5 indicated she thought the setting should be "3," and she indicated she would check the physician's orders to be sure. RN #5 tilted the tank to check its oxygen contents. RN #5 indicated the portable tank was empty and needed to be filled right away.

During observation on 6/7/11 at 2:50 p.m., Resident J was observed in bed. The resident's tubing was not connected to the oxygen concentrator near the bed, and the concentrator was not turned on.

This federal tag relates to Complaint IN00090903.

3.1-35(g)(2)

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CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure the resident's non-pressure wounds were assessed and care was planned and updated related to care of the wounds for 1 of 2 residents reviewed related to non-pressure wounds in a sample of 20. (Resident J) The facility also failed to ensure assessment and care was implemented related to a resident's pain following hip surgery for 1 of 1 resident reviewed related to pain after surgery in a sample of 20. (Resident B)

Findings include:

1. The clinical record for Resident J was reviewed on 6/6/11 at 2:45 p.m. The record indicated the resident was readmitted to the facility on 3/10/11 after hospitalization on 3/6/11 for treatment to a boil on the back. Treatment at the hospital had included surgical debridement of the wound, and follow-up care included use of a wound vac for management of the wound.

A physician's order from the surgeon treating the wound, dated 5/20/11, indicated, "D/C

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F 309	Continued From page 27 [discontinue] wound vac cont. [continue] wet to dry dressings until wound closed [symbol for with] Dakins 1/8 % strength. Dakins 1/8% strength sol [solution] apply to gauze 1 X D [daily] or prn [as needed]." Documentation in Nurse's Notes failed to indicate a complete assessment of the wound including measurements. Occasional Nurse's Notes from 5/20 through 6/6/11 indicated the wound had no odor and slight amount of sersanguinous drainage. On 5/29/11 at 11:00 a.m., a Nurse's Note indicated, "...Granulation present at margins of wound. [symbol for no] drainage or odor...." Documentation failed to indicate other assessment of the wound. On 6/6/11 at 3:45 p.m., the Director of Nursing (DON) was interviewed related to the ongoing assessment of the resident's wound since removal of the wound vac. The DON indicated she kept a binder containing documentation of residents' pressure wounds, but she did not keep a record of non-pressure wounds. She indicated nurses on the floor would be documenting non-pressure wounds, and she would check with the Medical Records Director to determine if the record of Resident J's wound to the back had gotten into the overflow record. On 6/6/11 at 4:05 p.m., the Medical Records Director indicated she was unable to find any records related to assessment of the wound on Resident J's back. The resident's Plan of Care related to the wound, dated 2/2/11, indicated a problem of "Surgical debridement to back [symbol for with] wound vac." The problem was updated 3/23/11 with a problem of "Altered skin integrity r/t [related to]	F 309		

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surgical I&D [incision and drainage] on back. The goal for 3/23/11 indicated, "Area will [followed by blank space]. Printed interventions on the care plan were related to the problem of pain related to impaired mobility related to Parkinson's disease. A handwritten intervention indicated, "Encourage rest & assist [symbol for with] repositioning [symbol for with] c/o [complaints of] pain." Documentation failed to indicate goals and interventions for management of the non-pressure wound had been developed.

During interview on 6/6/11 at 1:45 p.m., RN #5 indicated the dressing on Resident J's back is usually changed on second shift, unless the dressing comes off or is soiled. RN #5 indicated the wound is looking "wonderful." She indicated the wound has progressed better than she expected it would.

On 6/7/11 at 2:50 p.m., RN #5 was observed completing a skin assessment for Resident J. A sign on the resident's door indicated, "Stop. See Nurse before Entering." During interview at this time, RN #5 indicated she would gown and glove, since she would come in contact with the resident's skin, and the resident had a dressed wound which had been positive for MRSA (Methicillin Resistant Staphylococcus Aureus), but was no longer draining. Resident B was lying in bed, and the nurse assisted the resident to roll from side to side. A dressing with the date of 6/7/11 written on it was observed on the resident's left upper left back.

The facility's policy entitled, "Skin Management Program," dated 3/10, was provided by the Administrator on 6/7/11 at 3:40 p.m. The

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Procedure section indicated, "...All alterations in skin integrity will be documented in one of two skin evaluation reports depending on what type of wound - either pressure wound (white) or other wound (lavender)....The facility assigned wound nurse will complete a further evaluation of the wounds identified....The care plan will be initiated to include specific alterations in skin integrity...."

2. On 6/6/11 at 12:50 p.m., CNAs #2 and #16 were observed providing incontinence care for Resident B. CNA #16 indicated the resident's leg was "really hurting." She indicated she had surgery to the left but is hurting on the right, too. As the resident was moved from side to side and cleaned, she moaned and cried out "Oh." When asked if she was hurting, the resident indicated, "Um, hum." CNA #2 indicated they needed to tell the nurse about the resident's pain. CNA #2 also indicated the resident's stool was usually dark, which she thought was due to the resident's taking iron supplements.

On 6/6/11 at 2:20 p.m., LPN #7 and CNA #22 were observed at Resident B's bedside, as LPN #7 prepared to change the soiled dressing to the resident's buttocks. LPN #7 asked the resident, "You still don't feel good? You want a pain pill when we get done?" The nurse cleaned black stool from the resident's buttocks and then removed the soiled dressings, one to each buttock, and then completed the cleaning of stool. The buttocks were noted to have reddened areas on the right and left buttock. During interview at this time, LPN #7 indicated the left buttock was an open area. She indicated the right area, including the red dots, looked like excoriation to her. She indicated she could see some pin point

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open areas to the right buttock also. The resident moaned "Ouch" when the buttocks were cleansed with normal saline before the new dressing was applied.

On 6/6/11 at 5:15 p.m., Resident B was observed in bed. During interview at this time, she indicated her bowels were hurting. She indicated the bowels hurt when they tried to move. The resident indicated the left hip was hurting also. LPN #11 was notified of the resident's complaints of pain.

The clinical record for Resident B was reviewed on 6/6/11 at 3:10 p.m.

The record indicated the resident was readmitted to the facility on 5/16/11 following surgical repair to a left hip fracture following a fall from the wheelchair.

The American Senior Communities Nursing Admission Assessment, dated 5/16/11, indicated the resident had pain in the left hip and headache.

The Interim/Admission Nursing Care Plan/, dated 5/16/11, indicated related to pain: Problem: Resident has pain related to: hip fx [fracture]; Goal: Will have no pain; Interventions: Meds [medications] as ordered; Non-medication interventions such as rest, quiet environment, therapies as ordered; Notify MD if interventions are not effective."

Physician's orders, dated 5/16/11, included, but were not limited to, Acetaminophen 650 mg by mouth every four hours for mild pain and Lortab

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5/500 by mouth every 6 hours as needed for severe pain.

Nurse's Notes for 6/6/11 at 3:00 a.m. indicated, "C/O [complained of] pain PRN [as needed] pain med given for relief...Watery diarrhea Immodium given for relief bandages to buttocks changed r/t soilage...abd [abdomen]soft B/S [bowel sounds] X 4 quads [quadrants]...."

Nurse's Notes for 6/6/11 at 7:30 a.m. indicated, "Staples removed from L [left] hip 24 staples completely intact came out resident tolerated well...."

No further documentation related to assessment of the resident's hip pain or bowel pain was indicated in Nurse's Notes from 6/6/11 at 7:30 a.m. until 6/7/11 at 7:15 a.m.

Documentation failed to indicate pain medication was administered to the resident following the dressing change on 6/6/11 at 2:20 p.m.

A physician's order was received 6/6/11 at 5:30 p.m. to discontinue Lortab 5/500 mg as needed and "Start Lortab 5/500 mg, take i [one] po [by mouth] q [every] 6 [symbol for hours] routine."

The next Nurse's Note was 6/7/11 at 7:15 a.m., and indicated, "...C/O hip pain. rec'd prn [as needed] Lortab = eff [effective] [The order was changed the preceding day from prn to routine.]...."

During interview completed on 6/7/11 at 2:25 p.m., the Director of Nursing indicated she had a call out to LPN #7 to find out about further

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F 309	Continued From page 32 documentation of assessment of the resident's pain and care provided. During interview on 6/7/11 at 6:00 p.m., the DON indicated nursing staff had been inserviced one on one related to assessment for pain and documentation of pain assessment and effectiveness of pain medications. She also indicated she was "looking at prn [as needed] narcotic usage" to see if some should be routine instead of as needed. This federal tag relates to Complaint IN00090903. 3.1-37(a)	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were assisted with shaving and personal care to maintain a neat, well-groomed appearance and personal hygiene, and set up and assistance with dining to maintain good nutrition for 7 of 10 residents reviewed related to activities of daily living, and 1 resident who reported a concern related to care (Resident T), in a sample of 20. (Residents K, S, N, C, L, M, and R)	F 312		

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Findings include:

1. During observation of the lunch meal in the restorative dining room on 6/6/11 at 12:20 p.m.,

A. Resident K was observed seated at a table by himself, facing out the window. The resident's cheeks and chin were covered with gray stubble of whiskers about 3/8 of an inch long.

B. Resident K had a plate with lettuce topped with chicken salad, a bowl of beets, a bowl of red Jello, a bowl with Mandarin orange slices, and two glasses of lemonade in front of him. The resident's silverware was rolled in a white napkin to the right side of the plate. The closest staff was two tables away, seated feeding other residents. The resident was observed to pick up beets with his fingers and feed himself. The outside of the resident's cups had bits of orange section stuck to them, and his hands had chicken salad stuck to them. On the clothing protector on the resident's lap was chicken salad and orange sections, and the resident picked food up off the clothing protector with his fingers and attempted to feed himself that.

Review of the CNA Assignment Sheet, provided by the Assistant Director of Nursing on 6/6/11 at 10:05 a.m., indicated in Special Needs for Resident K: "...Res [resident] to be 1 on 1 for all meals. Staff to assist to RDR [restorative dining room] stay with resident while eating...."

2. During observation of the lunch meal in the restorative dining room on 6/6/11 at 12:20 p.m., Resident S was seated in his wheel chair pushed

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slightly back from the table. Staff was at other tables feeding other residents. His oxygen tubing was not placed to his nose, and his eyes occasionally drooped closed. In bowls in front of the resident were small mounds of pureed foods that appeared not to have been touched, and a cup with a lid and straw. The resident reached toward the cup two times, and each time his hand dropped back into his lap. The resident was brought to the attention of CNA #10, seated at another table, who lifted the resident's straw to his mouth, and the resident drank some of the liquid.

Review of the CNA Assignment Sheet, provided by the Assistant Director of Nursing on 6/6/11 at 10:25 a.m., indicated in the column "Dining Room, Assertive [sic] Device," "Needs to be fed."

During interview on 6/6/11 at 4:10 p.m., Restorative Aide #8 indicated if Resident S could feel himself, and if he doesn't want to eat, he doesn't.

3. During interview on 6/6/11 at 11:25 a.m., Resident N indicated he is supposed to be shaved two times a week, but he usually is shaved only once a week. The resident was observed at this time to be clean shaven, and the resident indicated he had just been shaved this morning.

4. During observation near the nurse's station on 6/6/11 at 12:30 p.m., Resident C was observed being pushed along in his wheel chair by CNA #2. Drops of fluid were falling from beneath the chair, and a voice was heard to say, "It's leaking from underneath," as the chair was wheeled toward

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the resident's room. CNA #2 indicated, "Let me go get [name of CNA #6]. CNA #6 and CNA #2 prepared to provide incontinent care for Resident C in his room. CNA #2 indicated the resident spilled his coffee everywhere, and CNA #6 indicated, "It's not just coffee - he drinks a lot of coffee." As the resident's brief was removed, a strong urine odor permeated the air. The outside of the pants and cushion of the chair were covered with fluid. CNA #6 indicated Resident C was a "third shift get-up" and had been changed after breakfast and now again after lunch.

5. During observation on 6/6/11 at 1:40 p.m., Resident L was observed in his wheel chair in the hallway near the nurse's station. The resident's cheeks and chin were covered with gray stubble of whiskers about 3/8 of an inch long.

6. During observation on 6/7/11 at 11:05 a.m., Resident M was observed in his wheel chair seated outside the therapy room door. The resident's cheeks and chin were covered with gray stubble of whiskers about 3/8 of an inch long.

7. On 6/7/11 at 11:05 a.m., Resident R rolled down the hall in his wheel chair and indicated he had been "looking for you all morning - aren't you the state [Indiana State Department of Health]?" During interview at this time, Resident R indicated he was dissatisfied with care. He indicated there was not enough staff to assist him and other residents with showers. He indicated he had gone as long as three weeks without a bath. On 6/7/11 at 4:30 p.m., review of Resident R's ADL [Activities of Daily Living] Record for May 2011 indicated the resident had showers on May 1, 3,

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F 312	Continued From page 36 6, 7, 13, and 22, 2011. No other showers were documented in May 2011. 8. During interview on 6/7/11 at 4:15 p.m., Resident T indicated the staff the facility has is good, but there is not enough for residents to get the help they need. He indicated he was able to provide most of his own care, but his roommate needed help, and often the roommate's call light was on for as much as half an hour before someone came to help him. The facility's policies related to care for activities of daily living were requested and were provided by the Administrator on 6/7/11 at 3:40 p.m. The policies were labeled "Nursing Skills Validation" with "Original date: 2/2010." The policy for "AM [morning care] indicated, "Skill...Shave male residents and address facial hair of female as applicable...." When interviewed on 6/7/11 at 6:00 p.m., in regard to the resident's being shaved as part of the AM Care, the DON indicated residents were shaved daily only upon request. This federal tag relates to Complaint IN00090903. 3.1-38(a)(3)(A) 3.1-38(a)(3)(D) 3.1-38(b)(2)	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		

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F 314	Continued From page 37 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident at risk for pressure ulcers had wounds assessed and tracked and that care plans were developed and/or updated and care and treatment provided as planned for 1 of 1 resident reviewed related to pressure ulcers following hip surgery in a sample of 20. (Resident B) Findings include: On 6/6/11 at 12:50 p.m., CNAs #2 and #16 were observed providing incontinence care for Resident B. When the resident's bed covers were removed, the resident's heels appeared moist. When interviewed at this time in regard to any skin problems the resident had, CNA #16 indicated her "bottom is broken down." CNA #16 indicated this was the third time since 6:45 a.m. that the resident had been cleaned up after a bowel movement. The resident's buttocks, including on a dressing to the right and left buttock, were soiled with soft dark/black stool. CNA #2 indicated, "Her patch [dressing] is coming off." During care, the cloth used to cleanse the buttocks of stool was observed to have small amounts of blood on it. The resident cried "Oh" and moaned as the area was	F 314		

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cleansed. CNA #2 indicated they needed to tell the nurse the dressing was coming off so it could be replaced, and about the resident's pain. CNA #16 indicated the nurse needed to put to down towels before she sprayed the resident's heels. During interview at this time, Resident B indicated her heels were hurting.

On 6/6/11 at 2:20 p.m., LPN #7 and CNA #22 were observed at Resident B's bedside, as LPN #7 prepared to change the soiled dressing. LPN #7 asked the resident, "You still don't feel good? You want a pain pill when we get done?" The nurse indicated she had sprayed Granulex on the resident's heels earlier in the morning. The nurse indicated the dressings to the resident's right and left buttocks were Allevyn Thin, which she did not like. The nurse cleaned dark stool from the resident's buttocks and then removed the soiled dressings, one to each buttock, and then completed the cleaning of stool. The buttocks were noted to have reddened areas about the same size on the right and left buttock. During interview at this time, LPN #7 indicated the left buttock was an open area. She indicated the right area, including the red dots, looked like excoriation to her. She indicated she could see some pin point open areas to the right buttock also. CNA #22 was assisting Resident B to maintain positioning on her right side during the dressing change, and leaned over the resident to observe the reddened buttocks. CNA #22 stated, "Oh, wow, yes." LPN #7 indicated she had just looked at the physician's order and would use an Allevyn dressing as ordered. The resident moaned "Ouch" when the buttocks were cleansed with normal saline before the new dressing covering the two buttocks areas was applied.

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LPN #7 indicated the resident was lying on the facility's standard pressure relieving mattress. The nurse indicated the resident was not using a specialty pressure reducing mattress.

CNA #22 indicated she had been off work for a week, and the resident's heels were looking and feeling much better. She indicated, "That one on the right was soft enough last week." She indicated the heels were much more firm now.

During interview on 6/6/11 at 3:45 p.m., the Director of Nursing [DON] indicated she keeps a binder of information on any pressure wound in the facility. The DON indicated she had only one pressure ulcer wound sheet for Resident B. A Pressure Wound Skin Evaluation Report, dated 6/1/11, indicated a Stage 2 pressure wound 5.5 cm long by 2 cm wide by 0.1 cm deep. The site of the ulcer was not indicated. Documentation on Pressure Wound Skin Evaluation Reports failed to indicate if there was an area on the right buttock or an area on the left buttock. Documentation failed to indicate pressure areas to the heel.

The clinical record for Resident B was reviewed on 6/6/11 at 3:10 p.m.

The record indicated the resident was readmitted to the facility on 5/16/11 following surgical repair to a left hip fracture after a fall from the wheelchair when she was on leave of absence.

The American Senior Communities Nursing Admission Assessment, dated 5/16/11, in the section related to the skin indicated the resident had bruises to the forehead, nose, eyes, right

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neck, abdomen, a scab on the nose, and staples to the left hip and upper thigh. No pressure areas to the heels or buttocks were indicated.

The Pressure Wound Risk Assessment, dated 5/16/11, indicated if any question was answered "yes," the resident was at risk for developing skin breakdown. Five "yes" answers were indicated on the assessment.

The Interim/Admission Nursing Care Plan, dated 5/16/11, indicated the resident had "Problem: Potential for skin breakdown related to: non-ambulatory by self. Goal: Will have no skin breakdown." All possible interventions were check-marked, and included, "Pressure ulcer risk assessment; Weekly skin checks by LN [licensed nurse]; CNA to do skin check with shower and to notify LN of abnormals; Assist resident with toileting and pericare after each incontinent episode; Pressure reducing/relieving/redistribution mattress; Pressure reducing/relieving/redistribution device in chair; Encourage 75 to 100% meal/fluid consumption and monitor consumption; Diet/Supplements as ordered."

The Treatment Record indicated a physician's order was implemented twice daily, beginning 5/26/11, for "Keep R [right] heel elevated preventative measure; cleanse R heel [symbol for with] NS [normal saline], apply granulex fluff & cover [symbol for with] Allevyn adhesive."

The first documentation in Nurse's Notes related to the heels was dated 6/1/11 at 3:00 p.m., and indicated, "...Tx [treatment] to Rt [right] heel skin intact...."

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The same Nurse's Note, dated 6/1/11 indicated, "...NO [new order] received NO tx to buttocks cleanse area [symbol for with] NS pat dry apply Silvadene and cover with Allevyn q [every] day r/t [related to] open area...."

During interview completed on 6/7/11 at 2:25 p.m., the DON indicated Resident B's comprehensive Minimum Data Set assessment would be due "tomorrow" and would address her needs related to pressure ulcers. The DON also indicated she had a call out to the nurse who cared for Resident B on 6/6/11, about her assessment of the resident's buttocks wounds. The DON provided a copy of a care plan, which she indicated had still been "in the computer," related to the resident's pressure ulcer to the buttocks. The Care Plan indicated, "Problem Start Date: 6/1/11 Skin: Resident has impaired skin integrity: Stage 2 Location: buttocks Goal Target Date: 8/28/11: Areas will show no signs of infection." Interventions not included on the Interim/Admission Nursing Care Plan, dated 5/16/11, indicated, "Measure areas weekly; Notify MD if interventions are not effective and/or for s/s of infections: redness, warmth, drainage, edema, foul odor; Pressure reducing/redistribution cushion in chair; Pressure reducing/redistribution mattress on bed; Pressure wound risk assessment quarterly; Wound care/treatment as ordered."

The facility's policy entitled, "Skin Management Program, dated 3/10, was provided by the Administrator on 6/7/11 at 3:40 p.m. The Procedure section indicated, "...All alterations in skin integrity will be documented in one of two

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F 314	Continued From page 42 skin evaluation reports depending on what type of wound - either pressure wound (white) or other wound (lavender). Pressure reduction devices are to be put in place immediately. The licensed nurse will notify the wound nurse of any alterations in skin integrity. The facility assigned wound nurse will complete a further evaluation of the wounds identified....The care plan will be initiated to include specific alterations in skin integrity...." This federal tag relates to Complaint IN00090903. 3.1-40(a)(1) 3.1-40(a)(2)	F 314		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a resident of oxygen therapy received oxygen consistently and at a level in accordance with physician's orders	F 328		

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F 328	Continued From page 43 for 1 of 1 resident reviewed related to oxygen therapy in a sample of 20. (Resident J) Findings include: During observation on 6/6/11 at 10:20 a.m., Resident J was observed in a sitting room with other residents listening to piano music. On the back of the resident's chair was an oxygen canister with tubing connected and on the resident by nasal canula. The resident's daughter was present, and she lifted the canister to show oxygen was in the canister. The canister was set at "2" LPM (liters per minute). During observation on 6/6/11 at 4:00 p.m., LPN #3 was requested to assist with observation of Resident J's oxygen administration. The resident was observed lying in bed on his right side. The resident's portable oxygen canister was observed hanging on the back of the chair without tubing attached. The resident's oxygen concentrator was observed next to the bed with no tubing attached, and the machine was not turned on. During interview at this time, LPN #3 indicated she did not know where Resident J's oxygen tubing was, and she would get him a new one to get his oxygen hooked up and started. During observation on 6/6/11 at 5:15 p.m., Resident J was in his geri-chair in the dining room with oxygen by nasal canula set at "2." The clinical record for Resident J was reviewed on 6/6/11 at 2:45 p.m. and indicated physician's orders for June 2011 including, but not limited to, an order originally received 3/10/11 for "O2 [oxygen] 3L [liters] via nasal canula continuously."	F 328		

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F 328	Continued From page 44 The resident's Plan of Care, with original date of 3/16/10, indicated a problem, "Potential for shortness of breath, chest pains, edema, high BP [blood pressure] due to history of CHF [congestive heart failure]. A second problem listed on the same plan of care was dated 2/2/11, and indicated, "O2 [oxygen] use res [resident] does remove O2 @ X's [at time] by self." Interventions included, but were not limited to, "...medications as ordered." During observation in the hallway outside Resident J's room on 6/7/11 at 10:55 a.m., RN #5 was asked to check the oxygen level and setting on Resident J's portable tank. During interview at that time, RN #5 indicated the tank was set at "2." RN #5 indicated she thought the setting should be "3," and she indicated she would check the physician's orders to be sure. RN #5 tilted the tank to check its oxygen contents. RN #5 indicated the portable tank was empty and needed to be filled right away. During observation on 6/7/11 at 2:50 p.m., Resident J was observed in bed. The resident's tubing was not connected to the oxygen concentrator near the bed, and the concentrator was not turned on. This federal tag relates to Complaint IN00090903.	F 328		
F 353 SS=F	3.1-47(a)(6) 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or	F 353		

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F 353	Continued From page 45 maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff was available to meet the nursing needs of residents timely for 10 of 10 residents reviewed related to care needs for activities of daily living (ADLs) in a sample of 20. (Residents R, D, F, U, K, S, N, C, L, and M) and 1 resident who reported a concern related to care (Resident T), in a sample of 20. The deficient practice had the potential to affect 74 of 74 residents at the facility. Findings include: On 6/6/11 at 12:50 p.m., documentation provided	F 353		

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on the work table in the Administrator's office included the staffing information for 6/6/11. On that date, the schedule indicated nurses were scheduled as follows: 3 on day shift, 4 on evening shift, and 2 on night shift. On that date, CNAs were scheduled as follows: 7 on day shift, 6 on evening shift, and 4 on night shift.

CNA Assignment Sheets were provided by the Assistant Director of Nursing on 6/6/11 at 10:25 a.m. The assignments included, but were not limited to, the following related to residents' care needs:
Front hall: 8 required assistance of at least two for some portion of care; 15 were incontinent or had incontinent episodes; 2 required feeding;
20 Hall: 9 required assistance of at least two for some portion of care; 15 were incontinent or had incontinent episodes; 1 required "stay with" during dining;
40 Hall: 10 required assistance of at least two for some portion of care; 13 were incontinent or had incontinent episodes; 3 required feeding or extensive assistance with eating;
60 Hall: 6 required assistance of at least two for some portion of care; 6 were incontinent or had incontinent episodes; 1 required feeding.

1. On 6/7/11 at 11:05 a.m., Resident R rolled down the hall in his wheel chair and indicated he had been "looking for you all morning - aren't you the state [Indiana State Department of Health]?" During interview at this time, Resident R indicated he was dissatisfied with care. He indicated there was not enough staff to assist him and other residents with showers. He indicated only three aides were on duty last night, and that "wasn't enough." He indicated he had gone as long as

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three weeks without a bath. On 6/7/11 at 4:30 p.m., review of Resident R's ADL [Activities of Daily Living] Record for May 2011 indicated the resident had showers on May 1, 3, 6, 7, 13, and 22, 2011. No other showers were documented in May 2011.

2. During interview on 6/7/11 at 4:15 p.m., Resident T indicated the staff the facility has is good, but there is not enough for residents to get the help they need. He indicated, "If it wasn't for [name of nurse] at night, this place would go to pieces. Last night there were just three aides for the whole place. When the state's in, there's plenty of help in the dining room, but we won't see it when the state's gone." He indicated he was able to provide most of his own care, but his roommate needed help, and often the roommate's call light was on for as much as half an hour before someone came to help him. He indicated he was asleep at night and didn't know if his roommate got help when he needed it. He stated, "The buzzers are all going. If I had a heart attack at night, I would lay down there and die."

3. During the Initial Tour on 6/6/11 at 10:05 a.m., CNA #6 was observed through the open door to the hallway in Resident F's room next to Resident F's bed with a Hoyer lift. CNA #6 was working without other staff assisting. Resident F was in bed, and the Hoyer lift sling was under the resident. CNA #6 turned the lift on, and the resident was observed being lifted from the bed. Review of the CNA Assignment Sheet for Resident F indicated "A2 [assist of 2] mechanical lift."

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4. During observation on 6/6/11 at 10:55 a.m., the call light for Resident D's room was on. During interview at this time, Resident D indicated she needed to be changed. The resident's visitor indicated staff was busy, and Resident D indicated she had already asked twice to be changed. At this time, a man entered the room, and indicated he was "Dr. [name], the eye doctor," and he closed the door. At 11:00 a.m., CNA #2 knocked on Resident D's door, cracked the door to look in, and stepped back. CNA #2 indicated she was planning to change the resident now, but the resident was having her exam. At 11:15 a.m., the call light for Resident D's room was observed to be on. The eye doctor was no longer in the room, and during interview at this time, Resident D indicated she had not been changed yet. At 11:20 a.m., Restorative Aide #8 answered the call light. During interview on 6/6/11 at 12:05 p.m., Resident D indicated her brief had been changed now, but she was soaked and her brief unchanged from 7:00 a.m. until after the eye doctor's visit.

During interview at the bedside of Resident D on 6/7/11 at 11:25 a.m., the resident was observed to have a bandage on the right forearm. The resident indicated a bruise on the arm "busted open" when she was turned in bed. The resident's visitor at the bedside indicated the resident was heavy, and it was hard for staff to turn her. He indicated one staff person was turning the resident, and it takes two to turn her. He stated, "When short-handed, you do what you can to get by." Review of the CNA Assignment Sheet for Resident D indicated in "Special Needs: ...Fragile skin, use 2 or more staff to pull up in the bed to prevent shearing...."

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F 353	Continued From page 49 5. During observation on 6/6/11 at 10:45 a.m., Resident U's call light was on. Coming from the room was CNA #16 who indicated she was getting ready to change the lady across the hall and would then return. At 10:55 a.m., the room of Resident U was entered. Resident U was lying in bed and indicated he was waiting for someone to take him off the bed pan. At 11:00 a.m., CNA #16 was observed returning to Resident U's room. [Between 10:45 a.m. and 11:00 a.m., CNA #16 was observed going in and out of two other residents' rooms in response to call lights.] At 11:10 a.m. Resident U's call light was observed on. CNA #16 asked Restorative Aide #8 to answer the call light, and Restorative Aide #8 entered the room, and from the hallway, Resident U was heard to ask to be gotten up into his wheel chair. CNA #8 turned off the light and exited the room. Resident U's room was entered, and during interview at this time, the resident indicated he wanted to get into his wheel chair, but it takes two to transfer him. The resident also indicated he was looking for his urinal. The resident's need for a urinal was brought to LPN #7's attention, and she indicated, "Hang on, [name of Resident U], I'll have to go get one." At 12:15 p.m., Resident U was observed seated in his wheel chair in his room. During interview at this time, the resident indicated he had no water pitcher, and had not received ice water today. He indicated he was wanting ice. Beautician #1 entered the room with a Styrofoam cup of plain water. A visitor indicated the resident needed ice for a soft drink she had brought. 6. During observation of the lunch meal in the restorative dining room on 6/6/11 at 12:20 p.m.,	F 353		

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A. Resident K was observed seated at a table by himself, facing out the window. The resident's cheeks and chin were covered with gray stubble of whiskers about 3/8 of an inch long. Review of the CNA Assignment Sheet for Resident K indicated, "ADL Assist Need: A2."

B. Resident K had a plate with lettuce topped with chicken salad, a bowl of beets, a bowl of red Jello, a bowl with Mandarin orange slices, and two glasses of lemonade in front of him. The resident's silverware was rolled in a white napkin to the right side of the plate. The closest staff was two tables away, seated feeding other residents. The resident was observed to pick up beets with his fingers and feed himself. The outside of the resident's cups had bits of orange section stuck to them, and his hands had chicken salad stuck to them. On the clothing protector on the resident's lap was chicken salad and orange sections, and the resident picked food up off the clothing protector with his fingers and attempted to feed himself that.

Review of the CNA Assignment Sheet, provided by the Assistant Director of Nursing on 6/6/11 at 10:05 a.m., indicated in Special Needs for Resident K: "...Res [resident] to be 1 on 1 for all meals. Staff to assist to RDR [restorative dining room] stay with resident while eating...."

7. During observation of the lunch meal in the restorative dining room on 6/6/11 at 12:20 p.m., Resident S was seated in his wheel chair pushed slightly back from the table. Staff was at other tables feeding other residents. His oxygen tubing was not placed to his nose, and his eyes

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CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 51	F 353		

occasionally drooped closed. In bowls in front of the resident were small mounds of pureed foods that appeared not to have been touched, and a cup with a lid and straw. The resident reached toward the cup two times, and each time his hand dropped back into his lap. The resident was brought to the attention of CNA #10, seated at another table, who lifted the resident's straw to his mouth, and the resident drank some of the liquid.

Review of the CNA Assignment Sheet, provided by the Assistant Director of Nursing on 6/6/11 at 10:25 a.m., indicated in the column "Dining Room, Assertive [sic] Device," "Needs to be fed."

During interview on 6/6/11 at 4:10 p.m., Restorative Aide #8 indicated if Resident S could feed himself, and if he doesn't want to eat, he doesn't.

8. During interview on 6/6/11 at 11:25 a.m., Resident N indicated he is supposed to be shaved two times a week, but he usually is shaved only once a week. The resident was observed at this time to be clean shaven, and the resident indicated he had just been shaved this morning.

9. During observation near the nurse's station on 6/6/11 at 12:30 p.m., Resident C was observed being pushed along in his wheel chair by CNA #2. Drops of fluid were falling from beneath the chair, and a voice was heard to say, "It's leaking from underneath," as the chair was wheeled toward the resident's room. CNA #2 indicated, "Let me go get [name of CNA #6]. CNA #6 and CNA #2 prepared to provide incontinent care for Resident

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F 353	Continued From page 52 C in his room. CNA #2 indicated the resident spilled his coffee everywhere, and CNA #6 indicated, "It's not just coffee - he drinks a lot of coffee." As the resident's brief was removed, a strong urine odor permeated the air. The outside of the pants and cushion of the chair were covered with fluid. CNA #6 indicated Resident C was a "third shift get-up" and had been changed after breakfast and now again after lunch. 10. During observation on 6/6/11 at 1:40 p.m., Resident L was observed in his wheel chair in the hallway near the nurse's station. The resident's cheeks and chin were covered with gray stubble of whiskers about 3/8 of an inch long. Review of the CNA Assignment Sheet indicated, "ADL Assist Need: A1 [assist of one]." 11. During observation on 6/7/11 at 11:05 a.m., Resident M was observed in his wheel chair seated outside the therapy room door. The resident's cheeks and chin were covered with gray stubble of whiskers about 3/8 of an inch long. Review of the CNA Assignment Sheet indicated, "ADL Assist Need: A1 [assist of one]." This federal tag is related to Complaint IN00090903.	F 353		
F 441 SS=D	3.1-17(a) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441	Continued From page 53 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff (CNAs #2, #16, and #22; LPN #7; RN #5) washed their hands/changed gloves to prevent spread of	F 441		

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F 441	Continued From page 54	F 441		

infection for 2 of 4 residents observed during care requiring the staff to use of gloves from a sample of 20. (Residents B and J)

Findings include:

1A. On 6/6/11 at 12:50 p.m., CNAs #2 and #16 were observed providing incontinence care for Resident B. The CNAs removed the resident's brief, cleansed the periarea, and cleansed a large amount of dark stool from residents buttocks and anal area. When the cleansing was completed, both CNAs removed their gloves, and without washing their hands or using hand sanitizer, donned fresh gloves to complete the resident's care.

1B. On 6/6/11 at 2:20 p.m., LPN #7 and CNA #22 were observed at Resident B's bedside, as LPN #7 prepared to change a soiled dressing to the buttocks. LPN #7 and CNA #22 donned gloves, and the nurse cleaned dark stool from the resident's buttocks and then removed the soiled dressings, one to each buttock, and completed the cleaning of stool. The buttocks were noted to have reddened areas about the same size on the right and left buttock. During interview at this time, LPN #7 indicated the left buttock had an open area. She indicated the area on the right buttock, including the red dots, looked like excoriation to her. She indicated she could see some pin point open areas to the right buttock also. LPN #7 and CNA #22 removed gloves, and without washing their hands or using hand sanitizer, donned fresh gloves. LPN #7 completed the dressing change to Resident B's buttocks wounds, and CNA #22 positioned Resident B in bed.

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F 441	Continued From page 55 2. On 6/7/11 at 2:50 p.m., RN #5 was observed completing a skin assessment for Resident J. A sign on the resident's door indicated, "Stop. See Nurse before Entering." During interview at this time, RN #5 indicated she would gown and glove, since she would come in contact with the resident's skin, and the resident had a dressed wound which had been positive for MRSA (Methicillin Resistant Staphylococcus Aureus), but was no longer draining. Resident B was lying in bed, and the nurse assisted the resident to roll from side to side, touching the skin with her gloved hands, during the assessment. When the assessment was completed, without removing her gloves or washing her hands, the nurse moved the resident's oxygen tubing from his portable canister on his wheel chair to his oxygen concentrator in his room, and placed the nasal canula on the resident's face. The facility's policy entitled "Peri-care" was provided by the Administrator on 6/7/11 at 3:40 p.m. Review of the Procedure section indicated, "...6. Apply gloves. 7. Remove disposable brief or pad. 8. Wipe off any excess feces....9. Roll brief or pad....10. Place brief or pad in plastic bag. 11. remove soiled gloves and wash hands. 12. Fill basin with warm water or wet clean cloth....13. Apply clean gloves...." 3.1-18(l)	F 441		